

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01356

01338

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 LIBERTYTOWN RFD</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE EDWARD BAKER</u>				4. DATE OF DEATH Month Day Year <u>JAN 28 1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 4 1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM EDWARD BAKER</u>				14. MOTHER'S MAIDEN NAME <u>BELLE JARMON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Mrs. C. E. BAKER BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Myocardial</u> <u>422-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-62</u> to <u>1-28-62</u> , that (I) (we) lost the deceased alive on <u>1-27-62</u> , and that death occurred at <u>4:10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Clifford E. Schott</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT MD.</u>				22d. ADDRESS <u>BERLIN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/1/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u> ADDRESS <u>Berlin Md</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Clifford E. Schott</u>	

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DATE OF BIRTH

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WILLIAM EDWARD BAKER

1935

WILLIAM EDWARD BAKER

WILLIAM EDWARD BAKER

APRIL 1935

OWN FACTORY BAKER

WILLIAM EDWARD BAKER

NO 11-2-3-4-5 M. E. BAKER

WILLIAM EDWARD BAKER

WILLIAM EDWARD BAKER

WILLIAM EDWARD BAKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01357

01339

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> <u>CO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> c. LENGTH OF STAY in lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> d. STREET ADDRESS <u>1</u>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Irving</u> First <u>Bennett</u> Middle <u>Life</u> Last <b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>19</u> Year <u>1962</u>				<b>5. SEX</b> <u>m</u> <b>6. COLOR OR RACE</b> <u>cl</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>March 13-1875</u> <b>9. AGE</b> (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Funeral Hlp.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Funeral</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Stockton</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Alfred Bennett</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Maryanne Collins</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Elizabeth Bennett</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>ACUTE PULMONARY EDEMA</u> DUE TO (b) <u>CHRONIC MYOCARDIAL INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>cerebral vascular accident 1953</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hr</u> <u>10 yrs</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>				<b>21. I certify that (I) (his hospital)</b> attended the deceased from <u>1948</u> , 19 <u>1-15-62</u> to <u>1-19</u> , 19 <u>62</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>1-15-62</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Robert C. LaMar</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert C. LaMar, M. D.</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>5 NORTALL, Md.</u> <b>22b. DATE SIGNED</b> <u>1-19-62</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1-22-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Home Beneficial Cem</u> <b>23d. LOCATION</b> (City, town or county) <u>Stockton Worcester Co md</u> (State) <u>  </u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Booker M West</u> ADDRESS <u>  </u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u> <b>DATE</b> <u>JAN 23 '62</u>					



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01340

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>mo's</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Snow Hill Rd.</u>				d. STREET ADDRESS <u>Snow Hill</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Agnes Coston</u>			4. DATE OF DEATH Month Day Year <u>January 1 1962</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-61</u>		9. AGE (In years last birthday) yrs. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert L. Coston</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie A. Burton</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Carrie A. Coston</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute interstitial Pneumonitis</u> DUE TO (b) <u>525X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Robert C. Lamar</u>		M.D.		DATE SIGNED <u>January 3, 1962</u>	
EXAMINER'S NAME (Type) <u>Robert C. Lamar, M.D., 104 Bay Street,</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Snow Hill, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-4-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill Cem</u>	22d. LOCATION (City, town, or country) <u>Snow Hill Md.</u>	(State)	
23. FUNERAL DIRECTOR <u>Booker M. West,</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01359  
CERTIFICATE OF DEATH  
01341

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>4 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route # 3</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN, Md</u> d. STREET ADDRESS <u>1 Route # 3</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA</u> <u>HARGETT</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>11</u> <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FORNEY PRIDGETT</u>	
14. MOTHER'S MAIDEN NAME <u>HANNAH PRIDGETT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>118-12-1234</u>		17. INFORMANT <u>Mrs. Ida Wade - Berlin, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident with right hemiplegia</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-vascular Disease</u> DUE TO (c) <u>Several Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 1/2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Several Years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> , to <u>Jan. 11, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 11</u> 1962, and that death occurred <u>6:16 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Henry U. Sully, Jr.</u> M.D.		22b. DATE SIGNED <u>1/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, M.D.</u>		22d. ADDRESS <u>Berlin, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-14-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cem</u>		23d. LOCATION (City, town or county) (State) <u>Berlin, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Solley</u> ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>			

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VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
01360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 01342										
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>J.</u> Last <u>Hudson</u>					4. DATE OF DEATH Month <u>JAN</u> Day <u>13</u> Year <u>1962</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 16, 1909</u>		9. AGE (In years last birthday) <u>52</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BISHOPVILLE MD RFD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>—</u>					14. MOTHER'S MAIDEN NAME <u>Lizzie Hudson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>217-14-2489</u>		17. INFORMANT <u>MR. THOMAS HUDSON</u>			Address <u>SHARPTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>932.5</u> DUE TO <u>Exposure to cold</u> Approx 6 hrs Conditions, if any, which gave rise to immediate cause (b) <u>Alcohol Intoxication (0.21% in spinal fluid)</u> Unknown (a), stating the underlying cause last. DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Evidently became unable to walk due to Ethanol and then died from exposure to freezing cold</u>								
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>Exact time unknown</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Found on roadside</u>		20f. (City or town) <u>R-1</u>		(County) (State) <u>Worcester Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Francis J. Townsend, Jr.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Francis J. Townsend, Jr.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <u>Worcester County</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/20/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD RFD</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>					ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasner</u>	



1  
TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01361  
CERTIFICATE OF DEATH

01343

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>		c. LENGTH OF STAY IN Yr <b>10 Yrs</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>XX</b>				d. STREET ADDRESS <b>Pacific Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fayette Hall Layton</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>13,</b> Year <b>1962 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 13, 1909</b>	
9. AGE (in years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months <b>52</b> Days <b>13</b>		IF UNDER 24 HRS. Hours <b>13</b> Min. <b>19</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Fred Hall</b>			
14. MOTHER'S MAIDEN NAME <b>Jennie Marshall</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b> <b>XX</b>			
16. SOCIAL SECURITY NO. <b>216-10-1838</b>				17. INFORMANT <b>David Layton</b> Address <b>Pacific Ave. Ocean City, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion acute</b> <b>420</b> DUE TO (b) <b>Arterio-sclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <b>39 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>Jan 59</b> <b>Jan 13 62</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13 62</b> to <b>Jan 13 62</b> , that (I) (we) last saw the deceased alive on <b>Jan 13 62</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Francis J. Townsend Jr</b>				22b. DATE SIGNED <b>Jan 15, 62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Francis J. Townsend Jr</b>				22d. ADDRESS <b>Ocean City, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 1/16/62</b>				23b. DATE THEREOF <b>1/16/62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>New Hope</b>				23d. LOCATION (City, town or county) (State) <b>Willards, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Sillyville, Del.</b>				25. REC'D BY REGISTRAR DATE <b>JAN 17 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

01861

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01362

01344

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
c. LENGTH OF STAY IN TB <u>10 yrs.</u>		d. STREET ADDRESS <u>R. 7, B.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ward</u> First <u>P. Murray</u> Middle <u>D.</u> Last		4. DATE OF DEATH <u>Jan.</u> Month <u>24</u> Day <u>1962</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Van Murray</u>		14. MOTHER'S MAIDEN NAME <u>Nancy E. Shan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-03-4336</u>	
17. INFORMANT <u>Berdie Murray</u> Address <u>Seebynell Rd. R. 7, B.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>60</u> , to <u>Nov 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>61</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. V. Wood</u> M.D.		ADDRESS (Street, city or town, state) <u>Millsboro, Delaware</u> DATE SIGNED <u>1/24/62</u>	
PHYSICIAN'S NAME (Type) <u>G. V. Wood</u>		<u>Millsboro, Delaware</u> <u>1/24/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan. 27</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's</u>	22d. LOCATION (City, town, or county) (State) <u>Seebynell Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u> ADDRESS <u>Brown City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

1965



PLACE OF DEATH Home		DATE OF DEATH 10-10-65	
DECEASED John Doe		AGE 45	
SEX Male		RACE White	
MARRIED Yes		EDUCATION High School	
OCCUPATION Teacher		RESIDENCE 123 Main St, Baltimore, MD	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease	
FUNDAMENTAL CAUSE Atherosclerosis		PRE-EXISTING DISEASES Hypertension, Diabetes	
SIGNS AND SYMPTOMS Chest pain, shortness of breath		HISTORY Long history of heart disease	
TREATMENT Aspirin, nitroglycerin		POST-MORTEM EXAMINATION Not performed	
CERTIFICATE OF DEATH This is to certify that the above is a true and correct statement of the facts as reported to me by the attending physician or other qualified person.		SIGNATURE OF REGISTRAR [Signature]	
DATE OF REGISTRATION 10-15-65		PLACE OF REGISTRATION Baltimore, MD	

1. Name of deceased  
2. Date of death  
3. Age  
4. Sex  
5. Race  
6. Marital status  
7. Education  
8. Occupation  
9. Residence  
10. Cause of death  
11. Manner of death  
12. Immediate cause  
13. Intermediate cause  
14. Fundamental cause  
15. Pre-existing diseases  
16. Signs and symptoms  
17. History  
18. Treatment  
19. Post-mortem examination  
20. Certificate of death  
21. Signature of registrar  
22. Date of registration  
23. Place of registration



## CERTIFICATE OF DEATH

Reg. Dist. No. 11345

01363

Item 6, Film G-307-2/20/62, c.c.c.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	c. LENGTH OF STAY IN 1b <u>33 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Clayton</u> Last <u>Oakes</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Month <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Irishville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clayton Oakes</u>	
14. MOTHER'S MAIDEN NAME <u>Kathryn Bodley</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Letitia Short Oakes</u> Address <u>Berlin, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1 -</u> , 19 <u>61</u> , to <u>Jan 18 -</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan 18 -</u> , 19 <u>62</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>1-19-1962</u>			
ACTUAL SIGNATURE <u>Chas. R. Law</u> M.D.		PHYSICIAN'S NAME (Type) <u>Berlin Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/21/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Men's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Seabrook Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u>		24. REC'D BY REGISTRAR <u>Arthur L. Kneass</u> 24b. REGISTRAR'S SIGNATURE DATE <u>JAN 22 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

01364  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> c. LENGTH OF STAY IN 1b <b>20 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>609 Market Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b> d. STREET ADDRESS <b>1 609 Market Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Hess</b> Last <b>Shettleworth</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1880</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	11. IF UNDER 24 HRS. Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Bethel, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Hess</b>		14. MOTHER'S MAIDEN NAME <b>Margaret M. (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>Husband: Thomas Shettleworth, Pocomoke, Md.</b>		Address <b>Pocomoke, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>4 20</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertensive Cardio-vascular Disease</b> DUE TO (b) <b>30 min.</b> DUE TO (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial Hemiplegia, left (from old Cardio-vascular accident (1950))</b>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April, 1953</b> to <b>Jan. 15, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 15, 1962</b> , and that death occurred at <b>630 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Charles W. Trader</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b> 22d. ADDRESS <b>302 Market St., Pocomoke City, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1-17-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Edgehill</b>		23d. LOCATION (City, town, or county) (State) <b>Pocomoke Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hubert O. Lewis</b>		25a. REC'D BY REGISTRAR <b>Arthur S. Harris</b> DATE <b>JAN 22 '62</b>	

CERTIFICATE OF DEATH

01384



Decedent's Name: [Illegible]  
Date of Death: [Illegible]  
Place of Death: [Illegible]  
Cause of Death: [Illegible]  
Age: [Illegible]  
Sex: [Illegible]  
Race: [Illegible]  
Marital Status: [Illegible]  
Occupation: [Illegible]  
Residence: [Illegible]  
Signature of Physician: [Illegible]  
Signature of Registrar: [Illegible]

Medical History: [Illegible]  
Manner of Death: [Illegible]  
Burial Place: [Illegible]  
Date of Burial: [Illegible]  
Signature of Burial Officer: [Illegible]

Witnesses: [Illegible]  
Date: [Illegible]  
Registrar's Office: [Illegible]  
City: [Illegible]  
State: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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X

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01365 CERTIFICATE OF DEATH 01347											
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u> d. STREET ADDRESS <u>1326 WILLIAMS ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN DANIEL SHOCKLEY</u>						4. DATE OF DEATH Month Day Year <u>JAN. 1 1962</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 28, 1904</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL SHOCKLEY</u>						14. MOTHER'S MAIDEN NAME <u>EMMA SCOTT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>K70 219-01-8489</u>		17. INFORMANT Address <u>MRS. J. D. SHOCKLEY BERLIN MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 420 - { DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary artery Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>instant.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>1/1</u> , 19 <u>62</u> to <u>1/1</u> , 19 <u>62</u> that (I) ( <u>we</u> ) last saw the deceased alive on <u>12</u> , 19 <u>62</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank E. Gantz Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/4/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Gantz Jr. M.D.</u>						22d. ADDRESS <u>5 Bay Street Berlin, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin Md</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>James L. Thomas</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 8 '62</u>											

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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01366

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01348

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Winter Quarters Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 8 Winter Quarters Drive	
3. NAME OF DECEASED (Type or print) First HATTIE Middle V. Last STEVENSON		4. DATE OF DEATH Month January Day 14 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1892
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Cashier		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence E. Stevenson		14. MOTHER'S MAIDEN NAME Rose P. Bratten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-14-8044	
17. INFORMANT Mr. J. C. Stevenson, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Gastro-intestinal DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma, abdominal viscera DUE TO (c) Carcinoma of the Breast, right.		INTERVAL BETWEEN ONSET AND DEATH Hours Months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 27, 1959, to Jan. 14, 1962, that (I) (we) last saw the deceased alive on Jan. 14, 1962, and that death occurred at 145am the causes and on the date stated above.			
22a. SIGNATURE Charles W. Trader M.D.		22b. DATE SIGNED Jan. 14, 1962.	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		22d. ADDRESS 302 Market St., Pocomoke City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-62	
23c. NAME OF CEMETERY Salem Methodist		23d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Knease			

07368

REPUBLIC OF DENMARK

Ministry of Foreign Affairs  
Copenhagen  
Denmark  
1952  
May 22, 1952  
Mr. [Name]  
[Address]  
[City]  
[Country]

Dear Sir:  
Reference is made to your letter of May 15, 1952, regarding the matter mentioned in the subject line.  
The Danish Government has been informed of the matter and is studying it.  
I am, Sir, very respectfully,  
Yours faithfully,  
[Signature]  
[Name]  
[Title]

Very truly yours,  
[Signature]  
[Name]  
[Title]  
Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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01367  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01349

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Stockton</b> c. LENGTH OF STAY IN 1b <b>5 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Holland Nursing &amp; Care Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b> d. STREET ADDRESS <b>1 Second Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>S.</b> Last <b>TULL</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>19 62</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1884</b>	9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b>	IF UNDER 24 HRS. Days <b>77</b> Hours <b>77</b> Min. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Clarence E. Stevenson</b>			14. MOTHER'S MAIDEN NAME <b>Rose P. Bratten</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. T. White Tull, Pocomoke City, Md.</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary oedema</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Degenerative Heart Disease, Atherosclerosis</b> DUE TO (c) <b>Years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial hemiplegia (Meningioma removed years (15) ago)</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19 50</b> to <b>Jan. 3, 19 62</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3, 19 62</b> and that death occurred at <b>906 am</b> from the causes and on the date stated above.						
22a. SIGNATURE <b>Charles W. Trader</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Jan. 4, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>		22d. ADDRESS <b>302 Market St., Pocomoke City, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-6-62</b>		23c. NAME OF CEMETERY <b>Salem Methodist</b>		23d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry D. Watson</b>		ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>



01367

CERTIFICATE OF DEATH

1. Name of Deceased: [Illegible]  
2. Sex: [Illegible]  
3. Age: [Illegible]  
4. Date of Birth: [Illegible]  
5. Date of Death: [Illegible]  
6. Place of Death: [Illegible]  
7. Cause of Death: [Illegible]  
8. Signature of Registrar: [Illegible]  
9. Date of Registration: [Illegible]  
10. Office: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

01368

01350

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <i>Worcester</i> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> g. LENGTH OF STAY IN 1b <i>32 yrs</i> h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <i>md</i> f. COUNTY <i>Worcester</i> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> h. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>mae</i> Middle <i>E.</i> Last <i>Ward</i>		4. DATE OF DEATH Month <i>January</i> Day <i>7</i> Year <i>1962</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 9 - 1896</i>	9. AGE (In years last birthday) <i>65 1/2</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hampton Virginia</i>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <i>John Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Sadie Bundlich</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Name <i>Informant M. Ward</i> Address <i>Snow Hill, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>175.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Respiratory failure</i> (c) <i>Cystadenocarcinoma of ovaries with metastasis</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i> <i>1 1/2 yrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec</i> , 19 <i>61</i> , to <i>Jan 8</i> , 19 <i>62</i> that (I) (we) last saw the deceased alive on <i>Jan 8</i> , 19 <i>62</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>David Rafat</i>		M.D. 22b. ADDRESS <i>104 Bay Street, Snow Hill, Maryland</i>		22c. DATE SIGNED <i>1/8/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>David Rafat, M. D.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan 10/62</i>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <i>Protestant Cemetery</i>	
23d. LOCATION (City, town or county) <i>Snow Hill</i>		23e. (State) <i>md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Clay E. Dummis</i>		ADDRESS <i>Snow Hill, md</i>		25. REC'D BY REGISTRAR <i>JAN 10 '62</i>	
25a. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>		25b. DATE			

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1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back of this certificate, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01369

01351

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BERLIN</b> d. STREET ADDRESS <b>1 LIBERTY TOWN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA ANN WEST</b>		4. DATE OF DEATH Month Day Year <b>JAN 8 1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 6, 1876</b> 9. AGE (In years last birthday) <b>85 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BERLIN MD RFD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSHUA J. NICHOLSON</b>		14. MOTHER'S MAIDEN NAME <b>LEAH POWELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Mr. C. THOMAS WEST, BERLIN MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Nephritis</b> <b>443X</b> DUE TO <b>Chr. Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Age &amp; Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 mo.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 6, 1961</b> to <b>Jan 6, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1962</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Chas. R. Law</b>		22b. DATE SIGNED <b>Jan 9 - 1962</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<b>BURIAL</b>		<b>1/10/62</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<b>RIVERSIDE</b>		<b>BERLIN RFD MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burdette Berlin Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

(M)

1130

Wagon 222  
1130

1130

Wagon 222  
1130

Libertytown  
Jan 8 62  
F W X  
Horsemen = own horse  
Lynn Powell

No. Mr. C. Thomas West, Greening MD

Greening River  
Greening River MD